



Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Other: _____
Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ Confirmed
☐ Probable
☐ No count; reason: _____

Pertussis

County _____

REPORT SOURCE

Initial report date ____/____/____
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know
Investigation start date: ____/____/____
Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Birth date ____/____/____ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

- ☐ ☐ ☐ ☐ **Cough** Cough onset date ____/____/____
☐ ☐ ☐ ☐ **Vomiting due to cough (post-tussive)**
☐ ☐ ☐ ☐ **Coughing in sudden bursts or fits (paroxysmal cough)** Onset date ____/____/____
☐ ☐ ☐ ☐ **Whoop**
☐ ☐ ☐ ☐ Cough at final interview
Cough duration (days) at last interview _____
Date of final interview ____/____/____
☐ ☐ ☐ ☐ **Cough lasting at least 2 weeks**
☐ ☐ ☐ ☐ **Temporarily stops breathing (apnea)**
☐ ☐ ☐ ☐ Episodes of turning blue (cyanosis)
☐ ☐ ☐ ☐ Sore throat or pharyngitis
☐ ☐ ☐ ☐ Runny nose (coryza)
☐ ☐ ☐ ☐ Seizures new with disease

Predisposing Conditions

Y N DK NA

- ☐ ☐ ☐ ☐ Chronic lung disease

Clinical Findings

Y N DK NA

- ☐ ☐ ☐ ☐ Pneumonia or pneumonitis
X-ray confirmed: ☐ Y ☐ N ☐ DK ☐ NA
☐ ☐ ☐ ☐ Acute encephalopathy
☐ ☐ ☐ ☐ Admitted to intensive care unit

Hospitalization

Y N DK NA

- ☐ ☐ ☐ ☐ Hospitalized for this illness
Hospital name _____
Admit date ____/____/____ Discharge date ____/____/____
Y N DK NA
☐ ☐ ☐ ☐ Died from illness Death date ____/____/____
☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccination

Y N DK NA

- ☐ ☐ ☐ ☐ Vaccine up to date for pertussis (if under age 15)
Date last vaccine prior to illness: ____/____/____
Type: ☐ DTaP/DPT ☐ TDaP ☐ Unknown
doses pertussis vaccine prior to illness: _____
Vaccine series not up to date reason:
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous infection confirmed by laboratory
☐ Previous infection confirmed by physician
☐ Parental refusal ☐ Under age for vaccination
☐ Other: _____ ☐ Unknown

Laboratory

Collection date ____/____/____

P N I O NT

- ☐ ☐ ☐ ☐ ☐ **B. pertussis culture (clinical specimen)**
☐ ☐ ☐ ☐ ☐ **B. pertussis PCR**

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to determine probable exposure and contagious periods

Days from onset:

Exposure period

-20 -7

o
n
s
e
t**Contagious period***

Contagious from symptom onset to 21+ days after start of paroxysmal cough

Calendar dates:

* If treated, ≤5 days after initiation of effective antibiotic therapy

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____
- ☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness
- ☐ ☐ ☐ ☐ **Epidemiologically linked directly to a culture or PCR confirmed case**
- ☐ ☐ ☐ ☐ Contact with lab confirmed case
Age of person from whom this case contracted pertussis: _____ days / months / years
- ☐ ☐ ☐ ☐ Congregate living Type: _____
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

Y N DK NA

- ☐ ☐ ☐ ☐ Work or volunteer in health care setting during exposure period
Facility name: _____
- ☐ ☐ ☐ ☐ Visited health care setting during exposure period
Facility name: _____
Number of visits: _____ Date(s): ____/____/____
- ☐ ☐ ☐ ☐ Exposure setting identified:
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ College ☐ Work ☐ Military
☐ Correction facility ☐ Church
☐ International travel
☐ Other, specify: _____ ☐ Unknown

☐ Patient could not be interviewed☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk**PATIENT PROPHYLAXIS/TREATMENT**

Y N DK NA

- ☐ ☐ ☐ ☐ Antibiotics prescribed for this illness Name: _____
Date/time antibiotic treatment began: ____/____/____ AM PM # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Work/volunteer in health care setting while contagious: Facility name: _____
- ☐ ☐ ☐ ☐ Visited health care setting while contagious
Facility name: _____
Number of visits: _____ Date(s): ____/____/____
- ☐ ☐ ☐ ☐ Face to face contact with newborns, unimmunized children, women > than 7 months pregnant or others at risk for severe complications
- ☐ ☐ ☐ ☐ Employed in child care or preschool
- ☐ ☐ ☐ ☐ Attends child care or preschool
- ☐ ☐ ☐ ☐ Household member or close contact in sensitive occupation or setting (HCW, child care, food)
- ☐ ☐ ☐ ☐ Documented transmission
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ Work ☐ College ☐ Military
☐ Correction facility ☐ Church
☐ International travel ☐ Other: _____ ☐ Unk
- ☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Prophylaxis of appropriate contacts recommended
Number of contacts recommended prophylaxis: _____
Number of contacts receiving prophylaxis: _____
Number of contacts completing prophylaxis: _____
- ☐ Exclude case from sensitive occupations or situations until 5 days of treatment complete or for 21 days
- ☐ Exclude susceptible close contacts under 7 years until 5 days of treatment completed or for 21 days
- ☐ Other Specify: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ____/____/____

Local health jurisdiction _____

Record complete date ____/____/____